Written Testimony

Health Care Provider and Insurer Costs and Cost Trends

Holyoke Health Center's Response

June 15, 2011

1. Our main source of revenue, by far, is from public payers. Changes in private insurance rates affect us as an employer but affect only a small percentage of our patients. However, as we continue to expand in the area, our insured patient population will diversify. As a health care organization in the western part of the state, we are very limited in where we refer patients for services. Holyoke Medical Center, our local community hospital, provides most inpatient adult care. Many of our specialists for adults are also affiliated with Holyoke Medical Center. Baystate Medical Center provides our inpatient pediatric care and some inpatient care for more complex adults. The pediatric subspecialists we use are generally affiliated with Baystate Hospital. Orthopedic care is most often provided by Shriners Hospital. It is only in the area of obstetrical services that our patients have a range of choices, utilizing Holyoke Hospital, Baystate and Mercy Hospital. So, for the most part, our service sites are determined by availability, not cost.

2. Cost increases from 2005-2010 have been driven by inflation, space, costs related growth, opening a new health center site in Chicopee, expansion efforts in all programs areas and capacity, patients need and growth in non reimbursable staff that provide essential services. From 2005 through 2010 HHC experienced a 34% increase in overall cost per individual patients served.

	2006	2007	2008	2009	2010	Total
Percent Increase from Base Year 2005	3%	7%	13%	3%	8%	34%
Primary Reason for increase	Inflationary	Inflationary and added costs related to planned increase in physical capacity.	Inflationary and added costs related to planned increase in physical capacity.	Inflationary	Inflationary with significant increase in professional wages to retain staff.	

3. Community Health Centers save overall health care costs, providing a solution to health care cost inflation. Our focus on patient centered primary care, emphasizing preventative care and chronic disease management saves dollars by reducing specialty care, emergency room utilization and inpatient care. We reduce long term complications of chronic diseases and improve quality of life. Our organization works constantly to provide the best quality care in the most cost effective, patient centered way possible. We continually evaluate our costs and our outcomes, looking for ways to provide the same or better care at a manageable cost.

   We have learned that team based care, employing a combination of physicians, nurse practitioners, physical therapists, dentists, pharmacists, nurses, nutritionists, social workers, health educators, medical assistants, and community health workers, in partnership with patients and families provides the highest quality, most cost effective care. A team based approach directs each team member to work to the maximum of her license or job description, allowing the highest cost team members to focus on care only they can deliver. The composition of the team will be different for each patient, depending on the patient's needs, but the team "menu" of possible care exists for all.

   Unfortunately, our current fee for service payment model limits the utilization of this approach. When only the highest cost team members are reimbursed, the majority of the work must be performed by those team members in order to allow the organization to survive. Recent Medical Home payment changes pay between $2.10 to $7.50 per member per month ($1.50 per member per month plus $0.60 - $6.00 per member per month for high risk patients based on patient age). These payments are not adequate to fully shift work from reimbursable team members to non-reimbursable team members. The payment structure also limits physicians and nurse practitioners from spending significant time meeting with case managers, communicating directly with specialists or communicating with patients outside of face to face visits. All of these types of interactions allow for efficient, organized care, but per member per month payments are inadequate for full utilization of these cost saving practices.

   Our health center has worked hard to implement and maintain team based organized care. We employ and utilize all the team members listed above. Of our 2,000+ patients with diabetes, over 700 had services from a community health worker and over 100 from a clinical pharmacist. These intervention have resulted in 50% of these patients with HgbA1c >9 moving to <9 and 64% with blood pressure >130/80 achieving blood pressure control of <130/80. Of our total 15,000 patients, over 1,300 saw a behavioral health coordinator and over 900 hours of therapy were given to uninsured patients by our social work interns. Many more patients could benefit from similar services, reducing costs and improving outcomes, with an adequate global payment system.

4. Empowering primary care to operate in a flexible, patient centered medical home, with a focus on outcome driven quality measures, will improve quality and reduce overall health care costs. Costs will likely rise in primary care, but this will result in much reduced specialty and hospital costs. Instituting adequate global payments, bringing behavioral health services into the primary care medical home, greatly streamlining reporting requirements and eliminating insurer based care will all contribute greatly to improved, lower cost health care in Massachusetts.

   Global payments sufficient to allow for team based care utilizing physicians, nurse practitioners, nurses, dentists, physical therapists, pharmacists, social workers, medical assistants, health educators and community health workers will give primary care organizations such as the Holyoke Health Center the flexibility to shift care to lower cost team members whenever possible. Physicians and other primary care providers will have the information needed to avoid duplication of services, medication errors and missed opportunities for interventions. Patients will have the education and support needed to participate as full partners in their health care, improving the chances for life style changes necessary for improved health. By lifting the burdens of care coordination, patient education and medication reconciliation, among other tasks, from the physicians, access will be opened for new patients. In a time of critical shortages in primary care providers, allowing physicians to concentrate on work only they can do will result in greater numbers of patients served.

   Behavioral health care has long been a "carve out" both in the medical community and in insurer management. This is a critical error. Mental health diseases such as depression and anxiety substantially impact a patient's overall health. Adherence to care plans for medical conditions is frequently poor in these patients. It is past time for mental health to come fully into primary care. Payment structures which allow for mental health services within primary care (including joint mental health and medical health group visits for certain conditions, therapists allowed to function on a team where a primary care provider rather than a psychiatrist is the prescriber, etc), and regulations which require mental health providers to communicate regularly with primary care providers would be a beginning.

   Significant costs could be saved by my organization by a streamlining of reporting requirements on the part of the state and insurers. As participants in the Patient Centered Medical Home Initiative, as grantees for a number of Department of Public Health initiatives and as providers of medical care to patients with Medicaid and various Medicaid MCOs, we are required to report on a tremendous number of measures, frequently repetitive, but with slight variations requiring separate reports. Approximately 25% of our employees spend some of their time fulfilling reporting requirements, at tremendous cost to the health center.

Finally, at least partially in response to requirements, insurers have entered the health care delivery system, generating unnecessary costs and fragmentation of care. All of the Medicaid MCOs have their own case management programs. These programs use billing data to identify patients and then offer services with little or no integration with the patient's medical home. Our health center has seen patients given case management both by the patient's team nurse at the health center and by a visiting nurse sent by the insurer, much to the patient's confusion. Letters have been sent to patients telling them to continue medications already stopped by their primary care provider. Home visits by nurses lacking cultural sensitivity have angered patients, estranging them from a primary care team they incorrectly identify with the offending nurse. Insurers need to be limited to paying for care. Health care organizations can better deliver care.

5. In the area of primary care, payment should recognize the comprehensiveness of services and the complexity, including socio-economic complexity, of the patients served. Well chosen health outcomes, which take into account the health status of a patient entering care, are a reasonable measure of quality and could be included in a payment model. Finally, shared savings will offer opportunities to enhance primary care reimbursement, allowing for further innovation in care delivery and adequate salaries and benefits to recruit health care team members into primary care.

6. As discussed in question #1, we have far fewer hospital choices in the western part of the state than are available in the greater Boston area. However, there are some limited choices here. Giving primary care providers information about both cost and quality measures would influence referral patterns, particularly in an ACO model where primary care providers would benefit directly from the resulting shared savings. Quality measures would need to include services necessary for the underserved patients we treat. Culturally sensitive translation services, transportation and a welcoming attitude toward poor, non English speaking patients would be important. Communication with the primary care provider before the patient is discharged to identify issues which might complicate post discharge care such as homelessness, mental illness in a care provider, and so on would reduce unnecessary readmissions.

7. The most valuable quality measures for us are those generated internally, from our patient registries and chart reviews. In another year or two we hope to be generating this information from our soon to be implemented electronic health record. Examples of reports we currently generate include
    - diabetes reports on HgbA1c, lipids, eye exams, foot exams, blood pressure and flu shots
    - mammograms due
    - pap smears due
    - HIV care including labs, immunizations and specialty care

The next most useful is notification from hospitals about emergency room visits or inpatient admissions.

Information sent from payers is generally based solely on billing data and is notoriously incorrect. Utilization information, on the other hand, is generated by payers and can be useful. Examples include frequent emergency room visits or patients with asthma who have not filled a prescription for controller medications. These reports, though not entirely accurate, help us identify patients who have fallen out of primary care. We then use community health workers to try to track down patients and re-engage them in care.

8. As a primary care organization, we cannot speak to hospital costs. However, we believe that quality is very important is establishing price in primary care. Because we offer a wide range of services to an underserved, impoverished population in a culturally competent setting with translation services available at every encounter, our costs will necessarily be higher than a practice which offers only traditional doctor-patient medical care. Global payments on the front end, coupled with well chosen quality outcome measures, and shared savings after care delivery could combine to adequately reimburse and support this medical home model. With shared savings based on actual costs saved this model could guarantee cost savings. However, if most shared savings goes to insurers already enjoying record profits, there will be little incentive for primary care practices to make the substantial investments in staff, delivery system redesign, and information technology necessary to achieve savings.

   As a community health center, we are a nonprofit organization driven by mission and commitment to care for the underserved. Dollars generated by an adequate payment model go to providing a broader range of care, funding innovations in care, and paying our providers and staff salaries which will recruit and retain excellent caregivers.

9. N/A

10. Consumers need to know the range of services included within a given price. For example, our prospective patients should know that we have insurance experts on site to help them enroll in any and all available insurance. They should know that we speak Spanish and that many members of our staff live in their community. They should know that our pharmacists can package all their medications in day by day packaging so that they never confuse medication times and that this assistance in Medication Therapy Management and financial support for ci-pays. We offer patient education around healthy living, cultural food shopping and cooking. We have parenting classes, diabetes education classes and self management support programs. Our pediatric dentists offer on site sedation when needed for special needs or very anxious children. These are examples of services which mean so

much to patients and which are included in our payment structure, often at a loss to the health center.

11. Our patients do not, in general, care very much about competitive pricing. They care about being treated with respect. They care about their language needs being met. They care about being able to get medications when they have no money for a co-pay. They care about being understood. It takes only a few experiences within a community of someone feeling disrespected in, for example, a hospital emergency room, for community members to choose not to go to that hospital, regardless of any price differential.

    Quality also matters to patients. Some will feel that a community health center or community hospital is not as good as a larger, often more expensive place. As an example, recently a patient was referred from a private practice to our health center for an autism evaluation. One of our pediatricians trained to do autism evaluations, at a loss to the health center, because such evaluations were not available in a timely manner in the community. The private practice parent was initially resistant to the referral, but after googling the pediatrician, was surprised to find that her credentials matched or exceeded those of the private practice physicians. Patients will respond to information about training and interests of providers at least as well as other quality indicators.

12. HHC has implement and acquired new service lines and capacity that directly responds to patient need. In fall 2011, outpatient radiology will be integrated onsite in partnership with Holyoke Medical Center. Because of the limitations with our area providers in the area of oral care, we are implemented cost effective programming for the state around dental needs at Western Ma Hospital and Holyoke Soldiers Home. We have learned how to cooperate with other partners in the community to enhance and not compete. These arrangements enhance service delivery, provide new access points for care and expanded capacity to the health center. The state should promote and spread successful models, provide support for implementation and continue to look for ways work with CHC's around innovative strategies of care.

13. Our organization is participating in the Patient Centered Medical Home Initiative which includes per member per month payments for all patients, enhanced for those requiring case management. Frankly, the payments at this point are so inadequate; it is difficult to draw conclusions about this type of payment structure. For children and adolescents who fit high risk criteria, we will be paid an additional $7.20 per year. It is challenging to imagine what enhanced care can be delivered for this sum. Payments for primary care will need to be substantially higher to truly transform care. Our clinical pharmacists, behavioral health coordinators, community health workers and parent educators are all examples of care givers

not eligible for fee for service payments. Global payments need to cover these care givers to truly fund team based care and realize savings.

a. Yes. Costs need to be met since medical billing is not adequate; primary care needs to be in a leadership role while integrating with other disciplines and specialty including pharmacy and hospital care. Our experience with SCO shows that patients are well managed but these dollars do not come to HHC for this programming. We believe that our organization and our CHC colleagues have the expertise in preventative and public health focused care and need to drive the planning and implementation of new systems and responses.

b. Not applicable

14 The cost drivers are many however our internal data shows that cost and inflation was held down because we had no capacity to recruit and retain new physicians Staffing is always a challenge and if we are unable to stay competitive with the market, we may lose medical staff or be unable to recruit staff for growth. HHC is not in a position to remain as competitive as we need to be because of multiple budget cuts, including grants and federal programs; we are absorbing many costs particularly in the area of Medicaid enrollment support, chronic disease managements, supportive patient programming, pharmacy co pays and barriers to expansion due to administrative and operational costs to grow. Gaps in services particularly in the area of behavioral health and pharmacy have driven programming in-house—ultimately providing improved care for patients but much higher cost for the organization

15 Additional cost drivers include the shortage of physicians in and entering the field of primary care and the cost of continuing to add capacity as more patients are directed to community health centers. As CHC's continue implementation of the medical home model, we anticipate added cost for these wrap around services which will increase cost in the community health centers but decrease the overall cost of health care. The reduction of funds available for adult dental services will lead to more complex health problems which will most likely be more of a cost burden to the system. The required adoption of Electronic Health Records is also another driver of cost that will have initial deceases in productivity and ongoing management and training.

16 Supplemental: As the health care environment continues to change throughout the state and the nation, local primary care providers continue to be overwhelmed by high demand from patients in need of care. Over the past two years, HHC has had the opportunity to conduct an ongoing needs assessment of individuals and families who remain uninsured, at risk of losing coverage and outside of primary health care. As a result, a number of internal and community strategies that may prove efficacious in successfully improving access, health outcomes and cost-effective care through systematic linkages to outreach, education, preventive care, and medical and chronic disease management while individuals are waiting to access care.

We have **implemented** a system of health care that keeps high risk and chronically ill uninsured and newly insured patients connected to primary medical care at HHC through

RN case management, care coordination and support services that maintain the linkage to preventive and comprehensive services while they wait for primary care appointments. This system is **currently not** sustainable without grant dollars but provides a new approach and care design that responds to need and ultimately will decrease preventable ED, hospitalization and improve health outcomes.

This includes work to **Identify** high risk and chronically ill uninsured and newly insured patients who have been referred to HHC from the Emergency Room as well as new and transfer patients who are waiting for primary care appointments and/or have entered the HHC system through a Same Day Care appointment. **Assess** these patients' current health care needs and **triage** identified patients to RN Care Manager for nursing follow-up visit, referral to mental health care and services, Chronic Disease Self Management programming, pharmacy "medication therapy management" programming, oral health care and other internal referral programs as needed. **Integrate** support services, health education and disease management through the Patient Navigator with a special focus on our partnerships and referral relationships. **Network** with other primary care providers/community health centers to ensure that appropriate referral to providers are made if the patient would like to seek care closer to home. (An analysis conducted this year showed that uninsured patients sought care at HHC from over 20 different cities and towns as far away as NY, VT and CT borders). **Track** progress and outcomes of each patient who have entered the system through the program and the impact of Patient Navigation through existing internal data systems e.g. UDS report, PECS registry, 340 B pharmacy enrollment and partner agency referral to evaluate outcomes, patient volume and impact of the project. **Spread** the model of patient navigation and chronic disease self management locally and statewide as a successful model of innovation to improve access, health outcomes and cost-effective care for the uninsured through outreach, education, preventive care, and medical management.